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ABSTRACT

This study examined the enrollment process for the State Children's Health Insurance Program (SCHIP) and the outcomes of that process. Data were collected during spring and summer of 2000 through telephone interviews with state program officials from eight states selected based on a variety of demographic and programmatic variables; the states were Alabama, California, Colorado, Florida, Michigan, Missouri, New York, and North Carolina. States had a difficult time producing outcome data and varied considerably in data collection and reporting practices. The major findings include the following: (1) states have implemented many similar strategies for simplifying the SCHIP enrollment process, but simplifications to Medicaid policies and procedures are less extensive; (2) inconsistencies between SCHIP and Medicaid eligibility rules and requirements made enrollment more difficult and confusing for families; (3) in most states, less than half of applicants were approved for SCHIP eligibility, with a large proportion referred to Medicaid; (4) large proportions of SCHIP applications were denied for procedural reasons; (5) SCHIP programs ask families about existing health insurance coverage as part of the application process, and deny coverage to families covered by other insurance; and (6) state SCHIP and Medicaid data systems are highly variable in their capacity to report eligibility outcome data. Implications of these findings for future policy include the need to ensure that appropriate referrals for Medicaid translate into approvals for Medicaid, to consider available alternatives for reducing the number of children denied coverage for procedural reasons or incomplete submissions, to monitor the relationships between public and private health coverage, and to improve states' administrative data systems. (A discussion of the limitations

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of state data systems is appended. Contains 13 references.) (KB)

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Getting In, Not Getting In, and Why
Understanding SCHIP Enrollment

Ian Hill
Amy Westpfahl Lutzky

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Assessing the New Federalism
An Urban Institute Program to Assess Changing Social Policies

SCHIP
State Children's Health Insurance Program Evaluation

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SCHIP
State Children's Health Insurance Program Evaluation

Assessing the New Federalism
An Urban Institute Program to Assess Changing Social Policies

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This report is part of the Urban Institute's *Assessing the New Federalism* project, a multiyear effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

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About the Series

Assessing the New Federalism is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, the project studies changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's web site. This paper is one in a series of occasional papers analyzing information from these and other sources.

Contents

Foreword vii

Executive Summary ix

Introduction and Background 1

Study Methods 2
- Collecting Information on Application Processes 3
- Collecting and Analyzing Application Outcomes Data 3

SCHIP Enrollment Processes 4
- Administrative Responsibility for Determining Eligibility 4
- SCHIP Application Processes and Efforts to Simplify 5

SCHIP Application Outcomes 9
- Rates of Approval, Denial, and Referral to Medicaid at Initial Application 9
- Reasons for Denial at Application 12

Conclusions and Implications for Future Policy 15

Notes 20

References 21

Appendix A: Limitations of State Data and Data Systems 23

About the Authors 25

Foreword

This is one of a series of reports exploring policy issues that have emerged during states' early implementation of the State Children's Health Insurance Program, or SCHIP. These reports seek to identify important challenges states have faced, explore the availability of data to analyze these issues, provide initial analysis of the effects of alternative policies and implementation strategies, and raise questions for further study. Because of the limited scope of these analyses, it is important to exercise restraint in drawing conclusions from study results; these reports are intended to provide preliminary analyses of complex issues, and early insights into their nature and possible resolution.

The authors would like to extend sincere thanks to the many people who assisted with the completion of this project. Caroline Taplin, our project officer at the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, provided strong leadership, guidance, and support through the paper's development. The federal interagency workgroup, put in place to guide the work of the task order contract, also played an integral role in setting the objectives for the study and providing feedback on all data collection instruments and drafts. Specifically, we want to extend our gratitude to Tanya Alteras, Steven Finan, Julia Paradise, Barbara Richards, Adelle Simmons, and Jennifer Tolbert at ASPE, Wendy Wolf, formerly of the Health Resources and Services Administration (HRSA), Karen Raykovich at HRSA, Cindy Shirk, formerly at the Centers for Medicare and Medicaid Services (CMS), and Christina Moylan, Angela Corbin, and Johanna Barraza-Cannon of CMS.

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Executive Summary

The Balanced Budget Act of 1997 established Title XXI of the Social Security Act, creating the State Children's Health Insurance Program (SCHIP). Title XXI provided states the authority and funding to expand health insurance coverage to low-income children by expanding Medicaid, developing new "separate" child health programs, or a combination of both approaches. During the first three years of SCHIP, considerable policy attention was directed at state efforts to enroll eligible children. Yet the program was often criticized for getting off to a slow start and enrolling a small percentage of the target population. Over time, states have designed and implemented numerous strategies to streamline the application process with the goal of achieving higher enrollment. As SCHIP programs have matured, national enrollment has increased steadily—between the second quarters of federal fiscal years (FFY) 1999 and 2000, enrollment grew by 90 percent (Rosenbach et al. 2001). Furthermore, the Centers for Medicare and Medicaid Services reported that in FFY 2001, 4.6 million children participated in SCHIP (CMS 2002). Nevertheless, with more than three-quarters of all uninsured children now eligible for public coverage, more needs to be learned about why these children are not enrolling in Medicaid or SCHIP (Dubay, Haley, and Kenney 2000).

Given policymakers' continued interest in enrolling eligible children into SCHIP and a more recent focus on improving retention rates in the program, the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) asked the Urban Institute to conduct a study of state efforts to enroll and retain children in SCHIP. Specifically, the Institute was asked to collect and analyze information about states' application and eligibility redetermination processes under SCHIP, as well as data on the outcomes of these processes. This report focuses on our findings related to enrollment; findings from our study of retention are examined in a companion report (Hill and Lutzky 2003).

Information and data were collected from eight states, selected based on a variety of demographic and programmatic variables, during the spring and summer of 2000. The states were queried on such issues as

- administrative responsibility for SCHIP eligibility determination;
- the process for accepting initial applications for SCHIP and how it differs from that of Medicaid;
- the "screen and enroll" process for SCHIP and Medicaid;
- strategies used to facilitate enrollment into SCHIP and Medicaid; and
- the processes by which applications are denied eligibility and families are notified of this denial.

We also discussed the lessons state officials had learned through the operation of these systems about the barriers that persist for families applying for SCHIP coverage, and strategies for overcoming these barriers.

The second component of the study involved the collection and analysis of application outcomes data. Specifically, we collected data on

- the number of SCHIP applications submitted, and of these, the number approved for SCHIP coverage, denied SCHIP coverage, and referred to Medicaid;
- the number of referrals to Medicaid that were approved, denied, or withdrawn;
- the number of eligibility denials that were due to "failure to meet eligibility criteria;" and
- the number of eligibility denials that were due to "failure to comply with procedures."

We typically found that states had a difficult time producing outcomes data, varied considerably in their data collection and reporting practices, and that no state could produce all of the measures of interest.

Findings and Implications for Future Policy

By collecting and analyzing information on the application processes states use for SCHIP and Medicaid, as well as administrative data on the outcomes of these processes, we had hoped to make informed observations regarding how various policy strategies affect rates of approval and denial of coverage. Because of limitations of state data systems and similarities in policies among our small sample of states, we were in most cases unable to draw such clear links. However, we did learn a great deal about the procedures states follow in accepting and reviewing SCHIP/Medicaid applications; the strengths and weaknesses of state eligibility data systems; the rates at which children are approved and denied coverage under SCHIP, and referred to Medicaid; and the various reasons why children are denied eligibility. The major findings of this study and their implications for future policy include the following:

- **States have implemented many similar strategies for simplifying the SCHIP enrollment process, but simplifications to Medicaid policies and procedures are less extensive.** In line with the national trend, the states we studied all made simplifying SCHIP enrollment a high priority. For example, all of our study states use a joint SCHIP/Medicaid application, permit these applications to be submitted by mail, and have dropped assets testing from eligibility criteria. Five of our eight study states had adopted 12 months of continuous eligibility for children enrolled in SCHIP. Two states have gone so far as to allow families to self-declare their incomes.

  It appears, however, that these states have not simplified their Medicaid enrollment processes to the same extent as their SCHIP processes. Among our eight study states, two still required face-to-face interviews for children enrolling in Medicaid (whereas SCHIP enrollment can be completed entirely by mail), two retained assets tests as part of their eligibility criteria, only four had adopted 12 months of continuous eligibility for Medicaid, and only one permitted families to self-declare income.

- **Inconsistencies between SCHIP and Medicaid eligibility rules and requirements make the enrollment process more difficult and confusing for families.** Inconsistencies between SCHIP and Medicaid eligibility rules and procedures may pose barriers to families wishing to enroll their children in coverage. State officials believed that these inconsistencies make the federally required "screen and enroll" process difficult and confusing, while also making children's transitions between SCHIP and Medicaid coverage more challenging.

- **In most states, less than 50 percent of applicants were approved for SCHIP eligibility. However, a large proportion of applicants appeared to be Medicaid-eligible and were referred to that program.** SCHIP approval rates of joint applications were less than 50 percent in four out of the five states submitting comparable data. In these same four states, roughly 40 percent of SCHIP applications were referred to Medicaid because applicant children appeared to be income-eligible for Medicaid coverage. This finding speaks to the critical importance of SCHIP's "screen and enroll" requirements, which aim to ensure that children are enrolled into the program for which they are eligible, and that enhanced federal matching dollars are targeted to the intended population. In addition, this finding reinforces anecdotal reports that SCHIP outreach and enrollment efforts may be fueling increased Medicaid case finding. Unfortunately, most states could not report on the outcomes of their referrals to Medicaid (i.e., regarding which children were granted Title XIX coverage and which were not) because of the limitations of their data systems.

- **Large proportions of SCHIP applications are denied for procedural reasons; this may be the unexpected down side of a simplified application process.** As states have increasingly implemented mail-in application procedures, they have also experienced higher rates of application denials for "failure to comply with procedures," and "incomplete" applications. In the three study states submitting comparable data, we found that between one-half and three-quarters of all eligibility denials were among families that failed to successfully complete the SCHIP application process. Nearly all of these denials were because families submitted incomplete applications, or applications that omitted required documentation and verification. Most often, it appears that missing income verification was the leading culprit in these denials.

  State officials speculated that these high rates of incompletes were likely a direct side effect of a mail-based application process, which, by its nature, introduces the potential for confusion and/or mistakes by families. Ironically, these officials noted that one advantage of the previous face-to-face intake process was that eligibility workers could directly discuss with parents the various items that needed to be submitted along with the application. Yet state officials generally agreed this trade-off was worth it, for it made application processes more acceptable to families and has led to a higher volume of applications.

- **SCHIP programs are asking families about existing health insurance coverage as part of the application process, and are denying coverage to those who possess it. However, it appears that only a small proportion of applicants already have insurance.** The Title XXI statute prohibits states from

enrolling children in SCHIP who already possess other forms of creditable insurance. Each state in our study, therefore, includes questions on its applications about whether applying children have existing coverage. We found that small proportions of children appear to already have insurance at the time of application—in four of the six states that could report on this indicator, less than 5 percent of applicants reported existing coverage.

- **State SCHIP and Medicaid data systems are highly variable in their capacity to report eligibility outcome data.** One of the most important conclusions of this study is that state administrative data systems cannot precisely report on the outcomes of the eligibility process. Even among states that could provide data we requested, the codes, definitions, and classifications of various data elements were inconsistent across states, making aggregation and cross-state comparisons difficult, if not impossible.

  If states are to make informed improvements in their eligibility policies and application systems, then they will need to make investments to improve their administrative data systems. At the national level, policymakers should consider whether developing standardized approaches for collecting, compiling, and reporting SCHIP and Medicaid application outcomes data would be beneficial.

Getting In, Not Getting In, and Why
Understanding SCHIP Enrollment

Introduction and Background

The Balanced Budget Act of 1997 established Title XXI of the Social Security Act, creating the State Children's Health Insurance Program (SCHIP). Title XXI provided states the authority, as well as approximately $40 billion over 10 years, to expand health insurance coverage to low-income children by expanding Medicaid, developing new "separate" children's health programs, or a combination of both approaches. During the first three years of SCHIP, states directed considerable policy attention at efforts to enroll eligible children. The program was perceived in some quarters as having gotten off to a slow start and was criticized for enrolling a low percentage of the target population. States have designed and implemented numerous strategies to streamline the application process and achieve higher enrollment. These strategies have included using joint applications to simultaneously screen applicants for SCHIP and Medicaid eligibility; allowing families to submit applications by mail, thereby eliminating the need for a face-to-face interview; providing 12 months of continuous coverage to children regardless of changes in their family situation; reducing the amount of verification that families must submit along with their applications; and granting children presumptive eligibility while their formal SCHIP application is reviewed. These efforts to simplify enrollment have been well documented by policy researchers (Cohen Ross and Cox 2000, 2002; National Conference of State Legislatures 2001; National Governors Association Center for Best Practices 1999; Rosenbach et al. 2001).

As the SCHIP program has matured, enrollment has increased steadily—between the second quarters of federal fiscal years 1999 and 2000, enrollment grew by 90 percent (Rosenbach et al. 2001). Furthermore, the Centers for Medicare and Medicaid Services reported that in federal fiscal year 2001, 4.6 million children were ever enrolled in SCHIP. Nevertheless, with more than three-quarters of all uninsured children now eligible for public coverage, more needs to be learned about why these children are not enrolling in Medicaid or SCHIP (Dubay, Haley, and Kenney 2000). Previous research suggests that lack of information about the programs, confusion about eligibility rules, and problems associated with the enrollment process reduce family participation (Cohen Ross and Cox 2000; Perry et al. 2000; Stuber et al. 2000). A more recent study has found that administrative hassles were a primary barrier to enrolling 10 percent of uninsured eligible children and 18 percent of families did not apply or even inquire about SCHIP and/or Medicaid because they did not think their child was eligible (Kenney and Haley 2001). These findings suggest that enrollment processes are complex and confusing to many families. Understanding the specific reasons why so many uninsured eligible children are not enrolled in SCHIP or Medicaid is important to guiding state enrollment efforts.

In light of policymakers' continued interest in enrolling eligible children into SCHIP and a more recent focus on improving retention rates in the program, the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) asked the Urban Institute to conduct a study of state efforts to enroll and retain children in SCHIP. With the assistance of a federal interagency workgroup, it was decided that the Institute would identify and analyze SCHIP application and eligibility redetermination processes and the outcomes of these processes. This approach would not only identify and highlight state policy efforts to streamline enrollment and improve retention, but also provide a context for requesting state data that could shed light on the various outcomes of states' SCHIP enrollment and redetermination efforts. This report focuses on our findings related to enrollment; findings from our study of retention are examined in a companion report (Hill and Lutzky 2003).

By coupling enrollment process information and outcomes data, this study is intended to help federal and state policymakers better understand

- what happens when families attempt to enroll and renew SCHIP eligibility;
- what proportions of children are approved and denied eligibility;
- the reasons why applicants fail to obtain coverage at intake; and
- what effects various simplification strategies are having on enrollment rates.

The remainder of this paper is organized into four sections. The first section describes the study's methodology, specifically discussing the way we selected our sample study states, collected information on application processes, and collected state data on application outcomes. We also discuss the limitations of these data and the difficulties we encountered in developing cross-state comparisons. The second section presents our findings about SCHIP enrollment processes, focusing on state efforts to simplify these procedures and identifying various process-related barriers to enrollment and retention that persist in the states. The third section reveals our findings about SCHIP application outcomes, presenting data on states' rates of approval and denial under SCHIP, and identifying the reasons why children appear to be denied eligibility at initial application. The fourth section summarizes our conclusions and discusses the implications of our findings for future federal and state policy related to SCHIP enrollment.

Study Methods

During the spring and summer of 2000, we requested information and data from eight states selected based on their diversity in size, population characteristics, geographic location, SCHIP program design, and ability to provide data on enrollment and eligibility redetermination outcomes. These states were Alabama, California, Colorado, Florida, Michigan, Missouri, New York, and North Carolina.

Among these eight states, only one—Missouri—implemented Title XXI solely through an expansion of Medicaid. The remaining seven created separate child health programs, either alone or in combination with Title XXI Medicaid expansions.

Collecting Information on Application Processes

Information on state enrollment processes was collected through telephone interviews with state program officials. A standard protocol was used to ensure consistency across the interviews. First, we reviewed and confirmed background information on each state's SCHIP program characteristics, information already collected under the Urban Institute's SCHIP evaluation.[1] This included information related to the design of each state's SCHIP program, income eligibility thresholds, implementation dates, and application procedures. Next, we explored how states' initial application processes worked, and queried states on the following issues:

- Administrative responsibility for SCHIP eligibility determination;
- The process for accepting initial applications for SCHIP and how it differs from that of Medicaid;
- The state's "screen and enroll" process for SCHIP and Medicaid;
- Strategies used to facilitate enrollment into SCHIP and Medicaid; and
- The processes by which applications are denied eligibility and families are notified of this denial.

Finally, we discussed the lessons state officials learned about barriers that persist for families applying for SCHIP coverage and strategies for overcoming these barriers. This initial qualitative assessment provided us the context for requesting and interpreting outcome measures.

Collecting and Analyzing Application Outcomes Data

The second component of the study involved the collection and analysis of application outcomes data with which we hoped to answer the following research questions:

- What proportions of children are approved and denied eligibility at SCHIP enrollment, and what portion are referred to Medicaid?
- What are the leading reasons children are denied SCHIP eligibility at initial application?
- What are the policy implications of these findings for both the design of the eligibility determination process, and the data systems that report the outcomes of this process?

To answer these questions, a standardized set of outcome measures was requested of all states. We requested data for two points in time—May 1999 and May 2000—to permit longitudinal comparisons. The data collected included

- the number of SCHIP applications submitted and, of these, the number approved for SCHIP coverage, denied SCHIP coverage, withdrawn, and referred to Medicaid;[2]
- the number of referrals to Medicaid that were approved, denied, or withdrawn;
- the number of eligibility denials that were owing to "failure to meet eligibility criteria" (including such reasons as excess income, ineligible age, excess resources,

insurance at time of application, dropped insurance within waiting period, or access to affordable insurance); and

- the number of eligibility denials that were owing to "failure to comply with procedures" (including such reasons as missing required verification of income, resources, Social Security number, age/birth certification, residency, citizenship/immigration information, or health insurance information), or failure to pay premiums or enrollment fees.

It is important to note that, across the board, states had a difficult time producing outcomes data, that states varied considerably in their data collection and reporting practices, and that no state could produce all of the measures of interest. Through the data collection process, we identified the following limitations of state data systems:

- **Unavailability of Medicaid data.** While we set out to collect both SCHIP and Medicaid data, most states could only provide Title XXI SCHIP data; and only one separate SCHIP program was able to provide Medicaid data.
- **Unavailability of SCHIP data from 1999.** While we had hoped to measure states' progress by observing data from both May 1999 and May 2000, most states were not able to provide specific point-in-time data for the earlier period given the newness of programs and systems. Thus, longitudinal comparisons were not possible.
- **Incomparable data across states.** Available state data were often reported inconsistently by states, with considerable variation in how they defined, classified, collected, and organized outcome measures. As a result, cross-state comparisons were difficult to make. Only five of the eight states were able to provide data on application outcomes that were comparable to one another.
- **Insufficient detail in reporting categories.** Some states could not report data on specific reasons children are denied eligibility. Others could report data on reasons related to children's failure to meet eligibility criteria, but could not report data related to procedural denials of eligibility.

A more detailed summary of the limitations of state data systems is included in appendix A.

SCHIP Enrollment Processes

This section discusses SCHIP enrollment processes in our eight states. In addition, it presents findings related to states' efforts to streamline these processes, potential barriers to enrollment, and the challenges of coordinating SCHIP and Medicaid enrollment processes.

Administrative Responsibility for Determining Eligibility

Under Medicaid, the federal statute requires that state or county government employees make determinations of eligibility. Under SCHIP, however, states estab-

lishing separate child health programs were extended flexibility to devise other arrangements for eligibility determination. We found, even among our small sample of states, considerable variation in the entities that maintained responsibility for this functions:

- **State-level agencies.** Just one state used a state-level agency to process SCHIP applications and renewals; a significant departure from the traditional county-level departments of social services that have historically conducted Medicaid eligibility reviews. In Alabama, at the time of our study, the ALLKids program contracted with the State Employees Insurance Board (SEIB) to conduct its enrollment and redetermination processes, while the remainder of the program's administrative responsibilities lay with the Alabama Department of Health.[3]

- **Not-for-profit agencies and private vendors.** In four other states with separate child health programs, agencies or vendors outside of government have been made responsible for SCHIP eligibility determination and redetermination. In Florida, the not-for-profit Healthy Kids Corporation reviews all applications and renewals for the state's KidCare program. California's Managed Risk Medical Insurance Board contracts with EDS Corporation to review all applications for the Healthy Families/Medicaid for Children program. In Colorado, the CHP+ program contracts with Child Health Advocates for its outreach and eligibility determination functions, while Michigan contracts with the enrollment broker firm Maximus to carry out these functions.

- **Managed care plans.** In New York, responsibility for eligibility determination and redetermination in Child Health Plus resides with participating managed health care plans.[4]

- **County social services departments.** Two states rely on more traditional administrative arrangements for the intake and review of program applications. In both Missouri and North Carolina, county department of social services, under the direction of the state Medicaid agency, conduct eligibility determination and redetermination for both the SCHIP and Medicaid programs.

To comply with federal "screen and enroll" requirements, agencies in most of our study states screen joint applications and refer those children that appear to be Medicaid-eligible to local social services offices. Only Michigan's vendor referred applications of children appearing to be Medicaid-eligible to a centralized Medicaid office for eligibility determination.

SCHIP Application Processes and Efforts to Simplify

Our interviews asked states about their application design (e.g., length, clarity, effort to make forms user-friendly), whether a joint application was used, procedures for submitting the application, verification requirements, and efforts to streamline the process. We also discussed application process characteristics that may be limiting the enrollment of eligible children into SCHIP.

State Efforts to Streamline the Application Process

Generally, all 50 states and the District of Columbia have made enrolling eligible children a policy priority and have taken significant steps to simplify the SCHIP and Medicaid application processes (Hill 2000). The enrollment policies of the eight study states are detailed in table 1, and the key streamlining/simplification practices they use are discussed below.

- **Application design.** All states in our sample have made an effort to create more user-friendly application forms, either by reducing the application page length (California reduced its application from 20 to four pages, with seven pages of instructions, in April 1999), or by crafting sometimes longer, but clearer, applications (e.g., Colorado implemented a 12-page application in January 2001 that expanded its previous four-page application by using a larger font and including more explicit instructions).

- **Joint application.** All seven separate child health programs in our sample have implemented joint applications to simultaneously screen children for both SCHIP and Medicaid.

- **Mail-in applications.** All the SCHIP programs in our sample accept applications submitted through the mail, encouraging enrollment by eliminating the need for a face-to-face interview with county social services staff. State officials praised mail-in applications as a more convenient option for parents who work during the hours that local social services offices are open, and as a way to avoid the stigma that parents may associate with visiting a local social services office.

- **Eliminating assets tests.** All the SCHIP programs in our sample do not include an assets test as part of the application process. Eliminating the assets test and basing eligibility on income, age, and insurance status make it easier both for families to apply and for eligibility workers to determine eligibility.

- **Reducing verification requirements.** Six of the study states eliminated the requirement that parents provide residency documentation and six eliminated the need to provide documentation of children's ages. States are increasingly allowing families to "self-declare" much of the information required for eligibility determination; Alabama, Florida, and Michigan allow applicants to self-declare their income under SCHIP, and Florida and Michigan also permit this under Medicaid. Reducing verification requirements is intended to make the application process more "user-friendly" and result in fewer denials based on failure to provide documentation.

- **Twelve months continuous eligibility.** Five of the seven separate child health programs and four Medicaid programs in our sample provide 12 months of continuous eligibility to children. Providing enrollees with 12 months of continuous eligibility is viewed as an important means of retaining children in the program because it reduces the frequency that families must participate in the eligibility redetermination process, and removes the requirement that families report changes in income and circumstances.

- **Presumptive eligibility.** New York and Michigan are the only two states in our sample that adopted presumptive eligibility. Presumptive eligibility (PE) provides

Table 1. Initial Enrollment Policies for Children in Separate SCHIP and Medicaid Programs, May 2000

State	Joint application	Mail-in application		Verification[a]						Continuous eligibility		12 months of presumptive eligibility		Income calculation	
				Income		Assets test									
		SCHIP	MA	SCHIP	MA	SCHIP	MA	Residency	Age	SCHIP	MA	SCHIP	MA	SCHIP	MA
AL	X	X		X					X	X			Net	Net	
CA	X	X	X	X	X			X	X	X				Gross	Net
CO	X	X	X	X	X		X			X				Net	Net
FL	X	X	X							X[b]		X	Gross	Net	
MI	X	X	X	X[c]	X[c]					X		X[d]		Net	Net
MO[e]	NA	NA	X	NA	X	NA	X			NA		NA		NA	Net
NC	X	X	X	X	X					X	X			Gross	Net
NY	X	X		X	X			X	X		X	X	X	Gross	Net
Total	7	7	6	4	6		2	2	2	5	4	2	2	3N; 4G	8 N

Sources: Cohen Ross and Cox (2000), and state SCHIP/Medicaid application forms.

NA = not applicable

a. In addition to income, assets, residency, and age, states must also request immigration status documentation for noncitizens.

b. Florida has 12 month continuous eligibility for children under age 5.

c. Michigan implemented self-declared income in August 2000.

d. Although Michigan officially has presumptive eligibility for SCHIP, it is not being implemented by the health plans.

e. Missouri is a SCHIP Medicaid expansion program, thus having a joint application and distinguishing between SCHIP and Medicaid in the table is not applicable.

children with short-term coverage while formal eligibility is being determined. Not all state officials agree, however, that PE is necessary, since so many other strategies have already simplified enrollment. Plus, PE adds the challenge of ensuring that families follow through with their formal application for full eligibility.

The enrollment policies of our eight study states generally reflect national trends.[5]

Persistent Process-Related Barriers to Enrollment

While the states in our study have worked to streamline the SCHIP enrollment process and have implemented a number of strategies to make it easier for eligible children to gain access to coverage, several process- and documentation-related barriers remain that could affect children's ability to enroll. Notably, some of these barriers relate to inconsistencies between the SCHIP and Medicaid policies and rules, which complicate the screen and enroll process. Specifically, state officials identified the following enrollment barriers that persist in their states:

- **Incomplete applications and missing verification.** Although mail-in applications offer a more convenient way for families to apply for SCHIP, this policy appears to present a trade-off—several states noted that they experienced increases in the numbers of incomplete applications they receive, applications that are missing documentation either because families don't understand the application questions and/or documentation requirements, or because they inadvertently submit incomplete packets. Income verification was described as the most common type of missing documentation. Only three of the SCHIP programs and two Medicaid programs in our sample allow self-declaration of income.[6]
- **Inconsistencies between Medicaid and SCHIP eligibility determination policies.** In many states, important differences exist between SCHIP and Medicaid eligibility policies and processes. While all the separate child health programs in our sample eliminated the requirement for face-to-face interviews, two of the sample states still required it for Medicaid. Four of the five separate programs that adopted 12 months continuous eligibility for SCHIP did not have this policy for Medicaid at the time of our study—thus Medicaid applicants were subject to more frequent eligibility redetermination. Several states in our sample used different methods for calculating income eligibility for their SCHIP and Medicaid programs at the time of our study: Florida and New York used gross income for SCHIP, but net income for Medicaid, thereby necessitating two separate eligibility calculations. In addition, before April 2000, New York's Medicaid and SCHIP programs defined households differently and still had different income deductions (e.g., while SCHIP counted everyone living in a household, Medicaid only counted immediate family members). Further, Medicaid programs tend to require more documentation: for example, while Alabama allowed SCHIP applicants to self-declare income, Medicaid applicants were required to submit income verification. Colorado waived the assets test for SCHIP applicants, but required it of Medicaid applicants.

  These differences between Medicaid and SCHIP eligibility rules reportedly complicated the application and "screen and enroll" processes, as well as joint application forms themselves. In cases where additional information is required for Medicaid eligibility screening, joint forms have had to request this information and

thus have been made longer than original separate SCHIP application. Most states believe that this is a worthwhile trade-off that permits more comprehensive eligibility screening, and have provided families with additional assistance in completing applications. For example, in April 2000, when New York switched from a separate SCHIP application to a joint application, the state also implemented its "facilitated enrollment" initiative through which community-based organizations assist families in completing the application forms. Joint forms also pose another possible consequence: Because SCHIP eligibility is strictly limited to uninsured children, joint applications must include questions about applicants' insurance coverage. Some potential Medicaid applicants may wrongly perceive that they, too, are ineligible for public coverage if they already possess health insurance and may not follow through with submitting their applications.

SCHIP Application Outcomes

In addition to qualitative information, we collected administrative data from the study states on the outcomes of their application processes. Specifically, we collected data on the number of SCHIP applications (and/or children) processed by the state and, of these, the numbers approved, denied, and referred to Medicaid; for those denied eligibility, we gathered data on the reasons they were determined ineligible. By coupling our analysis of administrative data with the qualitative information on states' enrollment procedures, we hoped to gain a better understanding of the effects that various policies and procedures have on the outcomes of these procedures. As described in the previous section, however, the data collection effort was challenging and inconsistent system designs and reporting structures among the states make neat comparisons difficult. These findings are summarized below.

Rates of Approval, Denial, and Referral to Medicaid at Initial Application

In analyzing states' data on application outcomes, it was determined that five states submitted comparable data—Alabama, California, Colorado, Florida, and Michigan. Each of these states shared with us data on the applications submitted to SCHIP through the primary agency or vendor responsible for application processing, and each could distinguish between the proportions of these applications that were approved, denied, and referred to Medicaid. Three additional states submitted useable data, but these data were not comparable with those of the other states for a variety of reasons and thus are presented separately in the tables, and discussed separately in our analysis.[7]

Table 2 presents the outcomes of the SCHIP application processes in the study states. Specifically, among the five states reporting comparable data, we found

- Approval rates for SCHIP eligibility ranged from 57 percent in Colorado to 29 percent in Michigan. In between these two extremes, Alabama, California, and Florida reported approval rates within 10 percentage points of one another—41, 47, and 37 percent, respectively.

Table 2. SCHIP Application Rates of Approval, Denial, and Referral to Medicaid, May 2000

State	Number processed	Percent approved	Percent denied	Percent referred to XIX
Alabama	1,937[a]	41	21	38
California	44,978	47	15	37[b]
Colorado	3,922	57	32	12
Florida	17,352	37	20	44
Michigan	3,237[a]	29	27	45[c]
Missouri	14,365	11	18	71[d]
North Carolina	9,274[a]	24	12	64[e]
New York	153,661[f]	71	29	—[g]

Source: Data collected for this report.

— = not available.

a. Total number of applications processed. Each application may include more than one child.

b. Referrals to Title XIX include 3,481 children in families with income in the Medicaid-eligible range, but whose parents chose to not have their applications forwarded to Medicaid for review. This represents 21percent of all "referrals" to Title XIX.

c. This high rate of referral to Medicaid may be because the state's upper income eligibility threshold for Medicaid is higher than the other study states—150 percent of the federal poverty level.

d. Missouri's high rate of referral to Medicaid is because under the state's Title XXI Medicaid expansion, social services departments review all program applications for both SCHIP and Medicaid, and reported data include all applications for both programs.

e. North Carolina's high rate of referral to Medicaid is due to the fact that, under the state's Title XXI Medicaid expansion, social services departments review all program applications for both SCHIP and Medicaid, and reported data include all applications for both programs.

f. Data provided are for first quarter, 2000.

g. In New York, health plans responsible for conducting SCHIP eligibility determination could not report data on referrals to Medicaid.

- Rates of SCHIP application denial ranged from 32 percent in Colorado to 15 percent in California, with Alabama, Florida, and Michigan reporting that between 20 and 27 percent of applications submitted to SCHIP were denied eligibility.
- The proportion of SCHIP applications that were referred to Medicaid as a result of screen and enroll efforts ranged from 45 percent in Michigan to 12 percent in Colorado. Rates of referral to Medicaid were 38 percent, 37 percent, and 44 percent in Alabama, California, and Florida, respectively.

As discussed in the previous section, the characteristics of the application processes in the study states are more similar to one another than dissimilar, and thus it is difficult to develop hypotheses as to why one state's rates of approval, denial, or referral are different from those of another state. In fact, in Alabama and Florida, where applicants are permitted to self-declare their income—a very progressive simplification strategy—rates of approval were lower than in California and Colorado, states that require the submission of income verification. The relatively high rate of referrals to Medicaid in Michigan could be because the state's Medicaid upper income threshold

for children of all ages is quite high—150 percent of the federal poverty level (FPL)—compared with the other study states, which set Medicaid upper income limits at 133 percent of FPL for children under age six, and 100 percent of FPL for older children.

Interestingly, it is among the three states that were split apart from the main analysis that we can more clearly explain how the characteristics of the application process and/or reporting systems affect the outcomes of interest. For example, Missouri's and North Carolina's relatively low SCHIP approval rates and very high Medicaid referral rates most likely reflect the fact that the state's single data system reports on the outcomes of all applications submitted to SCHIP and Medicaid. Thus, all of the applications submitted directly to Medicaid through social services offices are captured in the Medicaid "referral" rate. In the other states in our sample, the outcomes reported only reflect those applications that were submitted to SCHIP via mail, while other families who may have applied for Medicaid through local social services offices are not captured. Finally, New York's very high approval rate reflects that the state has presumptive eligibility (unlike the other study states), and these "approvals" include children that have been granted presumptive eligibility and do not omit those children who are ultimately denied eligibility after a formal review.

Overall, less than 50 percent of SCHIP applications were approved for Title XXI coverage in all but one of the five states that submitted comparable data. Furthermore, with the exception of Colorado, more than one-third of SCHIP applications were referred to Medicaid in these five states. This latter finding suggests that states are actively conducting "screen and enroll" under SCHIP. It also supports the claim often made by state officials that SCHIP outreach and eligibility simplification may be contributing to significant gains in Medicaid case finding. Unfortunately, however, states were inconsistent in their ability to precisely measure whether children referred to Medicaid were ever enrolled in that program. For example

- In Michigan, Missouri, and North Carolina, where the entities responsible for reviewing SCHIP applications are also responsible for Medicaid eligibility determinations, state officials told us that referrals to Medicaid could, essentially, be considered approvals for Medicaid.
- In Alabama, California, and Colorado, however, separate programs reported that no feedback loop existed between the SCHIP and Medicaid eligibility systems and, therefore, officials had no idea of what the outcomes were of their referrals to Title XIX.
- In California, the joint Healthy Families/Medi-Cal for Children application includes a "check box" in which families can indicate if they do not want their SCHIP application reviewed by Medicaid. In May 2000, nearly 3,500 children—or roughly 20 percent of those who would have been referred to Medicaid—were not actually forwarded to the Title XIX program because parents checked this box. State officials reported that this finding reflects the stigma that many families associate with Medi-Cal, either due to prior negative experiences with the application process or due to fear of "public charge" among Hispanic families who believe that enrolling in Medi-Cal may affect their ability to achieve citizenship for themselves or their families.

Reasons for Denial at Application

Applicants that are denied eligibility for SCHIP and Medicaid can be classified into two large groups—those that did not meet the program's eligibility criteria, and those who did not complete the application process or failed to provide all of the information needed to determine eligibility. (For the latter group, "failure to comply with procedures" is the common bureaucratic terminology used to describe this outcome.) In a perfectly working system, all denials of eligibility should arguably occur because applicants do not meet eligibility criteria. However, high rates of application denials for "failure to comply with procedures" are reflective of a potentially problematic enrollment process, one that is difficult for families to comply with and complete. To reduce the number of denials for "failure to comply with procedures," state officials have often looked for ways to simplify and streamline application procedures.

It is within this context that the results in table 3 can be observed. Once again, three of the eight study states are kept separate in the analysis because their data were incomparable with the other five. Furthermore, two of the five states that reported comparable data on initial application outcomes could not report on the reasons children were denied eligibility. Thus, table 3's results focus on just three states—California, Colorado, and Michigan. As displayed in table 3:

- Fairly low proportions of all applications appear to be denied SCHIP eligibility because children failed to meet the program's eligibility criteria. Rates of denial for this reason ranged from a high of 15 percent in Michigan to 3 percent in California.
- Significantly higher proportions of applications were denied because families failed to comply with procedures. On this measure, between 12 and 20 percent of all applications in California, Colorado, and Michigan were denied because families failed to complete the process.

Table 3. Reasons for Denial of SCHIP Eligibility at Initial Application, May 2000

State	Number processed	Total percent denied	Percent denied for failure to meet eligibility criteria	Percent denied for failure to comply with procedures
California	44,978	15	3	12
Colorado	3,922	32	12	20
Michigan	3,237	27	15	12
Alabama	1,937	21[a]	—	—
Florida	17,352	20[a]	—	—
Missouri	14,365	18	11	7
North Carolina	9,274[b]	12	7	5
New York	153,661[c]	29	8	21

Source: Data collected for this report.

— = data not available or not collected

a. Data on reasons for denial at application were not available.

b. Number of applications processed. Each application may contain more than one child.

c. Data provided are for first quarter, 2000.

Once again, it is difficult to explain these differences by observing the differences in the states' enrollment policies and processes. For example, on paper California's and Michigan's approaches appear almost identical—both have a joint SCHIP/Medicaid application; both permit application submission by mail and all applications are sent to an entity that is distinct from the states' social services department; and both require verification of income, but little else. Yet the outcomes of their processes are quite different.

Ironically, it is again easier to explain the findings of the states separated out from our analysis, likely because their policies and systems lead to incomparable and somewhat misleading results. For example, New York's relatively high rate of denials for procedural reasons may be because of the state's presumptive eligibility policy, leading to large numbers of families that are ultimately denied because they do not complete the formal application process.

We next explore the reasons for SCHIP application denials in more detail, dividing the discussion between denials for failure to meet eligibility criteria and denials for failure to comply with procedures.

Failure to Meet Eligibility Criteria

Children can be denied eligibility for not meeting any of a number of specific eligibility criteria established by the state in which they are applying. Our analysis found that, among children denied eligibility for not meeting these criteria, there was considerable variation in the specific reasons that children were declared ineligible. As illustrated in table 4,

Table 4. SCHIP Application Denials for Failure to Meet Eligibility Criteria, by Reason, May 2000

			Reason for denial (percent)						
State	Number processed	Percent denied due to eligibility criteria	Excess income	Over age limit	Had insurance	Dropped insurance too recently	Immigrant	Withdrew	Other
California	44,978	3	1	0	—	—	0	—	2[a]
Colorado	3,922	12	10	1	1	—	—	0	—
Michigan	3,237	15	6	0	1	0	0	—	7[a]
Alabama	1,937	—	—	—	—	—	—	—	—
Florida	17,352	—	—	—	—	—	—	—	—
Missouri	14,365	11	3	0	1	0	—	—	6[b]
North Carolina	9,274	7	3	0	2	0	0	—	1[c]
New York	153,661	8	0	1	4	—	—	—	2

Source: Data collected for this report.
— = data not available or not collected
0 = less than one percent
a. In California and Michigan, "other" represents applicants who already were enrolled in Medicaid
b. In Missouri, "other" represents various reasons for denial, including "moved," "no child in household," etc.
c. In North Carolina, "other" primarily represents children who moved out of the state.

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- In California and Michigan, the largest proportions of children not meeting SCHIP program eligibility criteria were denied coverage because they already possessed Medicaid, accounting for 2 percent and 7 percent, respectively, of all application outcomes. In both these states, living in families that possessed excess income was the second leading reason for denial.
- In Colorado, however, the largest proportion of children denied coverage for not meeting SCHIP eligibility criteria lived in families with income above the state's upper income threshold; this denial reason accounted for over three-quarters of all denials in this category and 10 percent of all application outcomes. Being over the SCHIP program's upper age limit and already possessing private insurance explained much smaller proportions of this state's criteria-related denials.

These dramatic state-to-state variations defy easy explanation. In California and Michigan, the fact that many children were denied because they already possessed Medicaid could be viewed as a marker of some families' dissatisfaction with Medicaid coverage and desire to obtain alternative coverage under SCHIP. In Colorado, higher rates of denials for possessing excess income might reflect the state's relatively lower income eligibility threshold of 185 percent of FPL.

Failure to Comply with Procedures

Children can also be denied SCHIP eligibility if their parents fail to successfully complete the application process. Such "procedural denials" can take many forms but, according to the data submitted for this study, they typically represent families that submitted incomplete applications (i.e., families failed to submit all of the documentation required to verify their family income, composition, residency, or citizenship). Specifically, as detailed in table 5:

Table 5. SCHIP Application Denials for Failure to Comply with Procedures, by Reason, May 2000

State	Number processed	Percent denied due to procedures	Reason for denial (percent)		
			Missing verification/ incomplete	Failed to pay premium/ enrollment fee	Other
California	44,978	12	11	—	1
Colorado	3,922	20	20	—	0
Michigan	3,237	12	11	—	1
Alabama	1,937	—	—	—	—
Florida	17,352	—	—	—	—
Missouri	14,365	6	6	—	—
North Carolina	9,274	5	1	3	0
New York	153,661	21	15[a]	2	4

Source: Data collected for this report.
— = data not available or not collected
0 = less than one percent
a. In New York, this proportion represents children who were granted presumptive eligibility, but who failed to complete enrollment for formal SCHIP eligibility.

- In the three states with comparable data, the submission of an incomplete application, or an application that was missing some or all of the verification required by the state, accounted for the vast majority of all denials for "failure to comply with procedures." In California, Colorado, and Michigan, this type of denial accounted for 11, 20, and 11 percent, respectively, of all application outcomes, and for between 89 and 99 percent of all denials for "failure to comply with procedures." While two of the states could identify specific types of missing documentation (e.g., California could report on families that were missing insurance verification and Colorado could report on families missing residency verification), the majority of cases in all three states were simply coded in a single unspecified code for "incomplete applications" or "missing documentation."
- In none of these three states were any procedural denials due to families' failure to submit premiums or enrollment fees. As all three states impose premiums on enrolled families in certain income ranges, this finding may reflect the fact that they either do not require the premiums as a condition for establishing eligibility, or that they permit families a grace period in which to submit their first payment.
- Interestingly, in two of the three states separated for this analysis—North Carolina and New York—some portion of children were denied eligibility for failure to pay premiums or enrollment fees. This finding suggests that a policy that requires submission of initial premiums in order to establish eligibility may result in increases in denials of eligibility.
- In New York, the compliance-related denials reported as "other"—4 percent of all application outcomes—were for families whose children were granted presumptive eligibility, but who failed to follow through and complete the formal application process.

Conclusions and Implications for Future Policy

This study documented the SCHIP application processes used in a sample of states, and also collected and analyzed state administrative data on the outcomes of those processes. By combining the study's qualitative and quantitative findings, we hoped to make informed observations regarding how various policies and program strategies appeared to affect actual rates of enrollment under SCHIP, as well as gain insights into the reasons children are denied eligibility and how various policies may be influencing these outcomes. Furthermore, we hoped to learn more about the data systems states use to report on SCHIP application outcomes and identify the strengths and limitations of those systems.

With this study now complete, we can conclude that we achieved many, but not all, of these goals. Through telephone interviews with states, we were able to learn a great deal about the procedures states follow in accepting and reviewing SCHIP applications. We were also able to collect much useful data from the states; while this effort was challenging, it did permit us to learn about the strengths and weaknesses of SCHIP eligibility data systems, and the variability in these systems from state to state.

In most instances, however, we were not able to draw clear links between the enrollment and redetermination policies states use, and the effects these policies have on outcomes. In the small sample of states we worked with, states' policies and approaches to enrollment were often more similar than dissimilar. As such, it was often difficult to interpret the findings in any given state and hypothesize whether differences between the states were because of particular policies they had adopted.

Presented below is a summary of the major findings of the study and a discussion of the implications of these findings for future policy and program design.

- **States have implemented many similar strategies for simplifying the SCHIP enrollment process, but simplifying Medicaid policies and procedures is less extensive.** In line with the national trend, the states we studied have all made simplification of the SCHIP enrollment process a high priority. As such, each has adopted many of the same strategies generally accepted as helpful in achieving this goal. For example, all of our study states use a joint SCHIP/Medicaid application, all permit these applications to be submitted by mail, all have dropped assets tests from eligibility criteria, and five of our eight study states have adopted 12 months of continuous eligibility for children enrolled in SCHIP. Two states have gone so far as to allow families to self declare their incomes.

  However, while Medicaid enrollment processes for children have also been greatly simplified in recent years, they had not been reformed to the same extent as SCHIP processes at the time our study was conducted. For example, among our eight study states, two required face-to-face interviews for children enrolling in Medicaid (whereas SCHIP enrollment can be completed entirely by mail), two retained assets tests as part of their eligibility criteria, only four had adopted 12 months of continuous coverage for Medicaid, and only one permitted families to self-declare income.

- **Inconsistencies between SCHIP and Medicaid eligibility rules and requirements make the process more difficult and confusing for families.** Our study identified several cases where states' SCHIP and Medicaid application rules and procedures were inconsistent with one another. State officials admitted that these inconsistencies may pose enrollment barriers for families referred from SCHIP to Medicaid. Furthermore, they noted that rule inconsistencies made the federally required "screen and enroll" process, as well as children's transitions between SCHIP and Medicaid coverage, more challenging.

- **In most states, less than 50 percent of applicants were approved for SCHIP eligibility; however, a large proportion of children appeared to be Medicaid-eligible and were referred to that program.** This study found that approval rates for SCHIP coverage using joint SCHIP/Medicaid applications were less than 50 percent in four out of the five states submitting comparable data. In these same four states, roughly 40 percent of SCHIP applications were being referred to Medicaid. This finding speaks to the critical importance of the Title XXI program's "screen and enroll" requirement, which aims to ensure that children are enrolled into the program for which they are eligible and that enhanced federal matching dollars are targeted to their intended population. Indeed, this finding also suggests that these states are aggressively and effectively conducting "screen and enroll," a finding consistent with that recently published by the Inspector General's Office

(USOIG 2001). In addition, this finding reinforces anecdotal reports suggesting that SCHIP outreach and enrollment efforts may be fueling increased Medicaid case finding.

From another perspective, however, this finding speaks to the need for states to take concerted steps to ensure that appropriate referrals to Medicaid translate into approvals for Medicaid. Unfortunately, in only three of the eight SCHIP programs we studied did SCHIP officials report that their SCHIP and Medicaid data systems were integrated and that they had access to information on the outcomes of their referrals to Medicaid; the other five states' eligibility systems were not linked. To the extent that eligibility rules, policies, and procedures in place for Medicaid are inconsistent with those of SCHIP, the ability to convert referrals into approvals may be seriously undermined. In addition, to the extent that any consumer-based stigma surrounds a state's Medicaid program, the ability to enroll large proportions of these referred children into Medicaid may also be weakened. Anecdotal evidence and limited earlier research suggest that in some states families with Medicaid-eligible children are often reluctant to apply for that program because of previous negative experiences either with the Medicaid eligibility process or with the Medicaid providers from whom they sought care, or because of fears that Medicaid enrollment constitutes a "public charge" and hurts their ability to achieve citizenship for their children (Hill 2000; Stuber et al. 2000).

- **Large proportions of SCHIP applications are denied for procedural reasons; this may be the unexpected down side of simplified application processes.** As described here and in other research, states have placed a high priority on simplifying their SCHIP and Medicaid application processes to facilitate families' enrollment of their children into coverage. Principal among these strategies has been to permit families to submit their applications by mail, thereby forgoing the need for a face-to-face interview with a social services eligibility worker. However, the results of this study, and our in-depth conversations with state officials, suggest that this particular simplification strategy may be fueling the unwelcome consequence of higher rates of application denials for "failure to comply with procedures," generally, and incomplete applications, specifically.

  As reported in the previous section, between one-half and three-quarters of all eligibility denials in the three states submitting comparable data were among families that failed to successfully complete the SCHIP application process. Nearly all of these denials were specifically due to families submitting incomplete applications, or applications that omitted required documentation and verification. As most states have substantially reduced their verification requirements under SCHIP and Medicaid and now typically only require that families submit documentation of income, missing income verification appears to be the leading culprit in these denials.

  State officials speculated that these high rates of "incompletes" were likely a direct side effect of a mail-based application process, which, by its nature, introduces the potential for confusion and/or mistakes by families. Ironically, these officials noted that one advantage of the previous face-to-face intake process was that eligibility workers could directly discuss with parents the various items that needed to be submitted along with the application. Yet state officials generally agreed this

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trade-off was worth it. In other words, they believed that mail-in application processes are more acceptable to families than those requiring face-to-face interviews, and likely generate a significantly higher volume of applications.

Yet there was less agreement among officials on how to address the problem of incomplete applications. Some believed that the answer lay in further refinement and clarification of application forms—that is, working to improve their user-friendliness and making instructions about the submission of supporting materials more explicit. However, other state officials believed that the best solution is to further reduce, or even eliminate, all verification requirements. Indeed, the experience in Michigan illustrates the potential benefits of this approach. In May 2000, the state saw 45 percent of its applications denied because of procedural reasons, and all of these were reportedly because of missing income verification. However, in September of that year, Michigan implemented a new policy that permits families to "self-declare" their income.[8] That month, Michigan saw its rate of denials due to incomplete applications drop to 12 percent, and officials report that this rate has dropped even further since.

Therefore, states may want to consider available alternatives for reducing the number of children that are denied coverage for procedural reasons and, more specifically, incomplete submissions. Ideally, the case of Michigan argues that if states' computer systems are sophisticated enough to allow for cross-checking and verification of applicants self-declared income within acceptable quality control parameters, then the elimination of all verification requirements may be a good alternative.

- **SCHIP programs are asking families about existing health insurance coverage as part of the application process, and are denying coverage to those who possess it. However, it appears that quite small proportions of applicants are already insured.** The Title XXI statute prohibits states from enrolling children in SCHIP who already possess other forms of creditable insurance. To comply with this requirement, each state in our study includes questions on its joint applications about whether applying children have existing coverage. Most states' data systems, in turn, capture and report those applicants who are denied coverage because they are already insured. It is perhaps encouraging to note that, in most states in this study, small proportions of all applicants appear to already have insurance—in four of the six states that could report data on this indicator, less than 5 percent of applicants reported existing coverage. While it is impossible to draw any firm conclusions from these limited data on the extent to which SCHIP holds the potential for crowding out private insurance, the data suggest that it will be important for policymakers to continue to monitor the dynamic relationships between public and private coverage.

- **State SCHIP and Medicaid data systems are highly variable in their capacity to report outcome data.** Perhaps one of the most important conclusions to be drawn from this study is that state administrative data systems cannot precisely report on the outcomes of the eligibility processes. While we found this to be true of both SCHIP and Medicaid systems, Medicaid systems in particular, due to their age and complexity, were reported as largely incapable of producing the outcome measures of interest. At one extreme, a number of states that we initially

approached for participation in the effort—including Indiana, Mississippi, and Pennsylvania, among others—ultimately could not participate because their data systems were unable to report the data we sought. (Most often, this was because data were collected and compiled at the county level and aggregation at the state level was difficult or impossible.) However, even among those states that could provide data, the codes, definitions, and classifications of various data elements were very inconsistent across states, which made aggregation of data and cross-state comparisons very difficult, if not impossible.

If states are to be able to make informed improvements in their eligibility policies and application systems, then they will need to make investments to improve their administrative data systems. At the national level, policymakers should consider whether developing standardized approaches for collecting, compiling, and reporting SCHIP and Medicaid application outcomes data might be beneficial. Perhaps state administrators, working with their federal counterparts, could discuss alternatives for optimal data collection and reporting of data through various national forums in place for SCHIP and Medicaid research and policy analysis.

This study provides a detailed look into the policies and procedures states use to determine SCHIP and Medicaid eligibility for children, as well as the outcomes of these processes as reflected by state administrative data. It is hoped that the insights gained here can help inform future, more in-depth evaluation efforts, as well as contribute to the dynamic and evolving efforts at the federal and state level to improve the effectiveness of SCHIP programs.

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Notes

1. The Urban Institute SCHIP evaluation is primarily funded by the Robert Wood Johnson Foundation and the David and Lucile Packard Foundation.

2. Or, if available, the number of children for whom applications were submitted, approved, denied, withdrawn, or referred to Title XIX.

3. In 2001, the enrollment function for ALLKids was transferred to the Department of Health.

4. In 2001, New York rolled out its new Facilitated Enrollment initiative whereby a broader range of community-based organizations, including managed care organizations, were authorized to conduct SCHIP eligibility determinations.

5. Of the 32 states that have separate SCHIP programs, 27 use joint applications; 28 of 32 separate child health programs and 38 of 51 Medicaid programs allow self-declaration for residency; 31 of 32 separate child health programs and 41 of 51 Medicaid programs have eliminated the assets test; 18 separate SCHIP programs and 14 Medicaid programs offer 12 months of continuous eligibility; and only five SCHIP programs and seven Medicaid programs have presumptive eligibility (Cohen Ross and Cox 2000).

6. Nationally, an even smaller proportion of SCHIP and Medicaid programs waive income documentation (8 and 7 states, respectively) (Rosenbach et al. 2001).

7. These three states are Missouri, North Carolina, and New York. Missouri and North Carolina submitted data on the entire pool of applications submitted to both SCHIP and Medicaid (as opposed to SCHIP only). For both states, joint SCHIP/Medicaid applications are submitted to and processed by county social services offices who conduct eligibility reviews for both programs. In both states the data system also combines and reports outcomes for both programs. New York was separated from the main analysis because the state could not report "referrals to Medicaid," most likely because SCHIP eligibility determination was, in May 2000, the responsibility of participating health plans, which were permitted to enroll children into Title XXI who appeared Medicaid-eligible on a presumptive basis and then refer them to the state for Title XIX review. In addition, the category of "approved" applications includes those children who were granted presumptive eligibility, and does not reflect whether these children followed through and received full program eligibility.

8. For quality control purposes, Michigan now relies on computer matching to verify families' reported income, and routinely runs applicant income information against files in the state's Department of Labor.

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Appendix A
Limitations of State Data and Data Systems

Through the data collection process of this study, we identified the following limitations of state data systems:

- **Unavailability of Medicaid data.** While we set out to collect both Title XXI and Title XIX data, most states could only provide Title XXI SCHIP data; and only one separate SCHIP program was able to provide us with Medicaid data. Title XIX programs were largely unable to produce detailed information on application outcomes, at least at the state level. State officials most often reported that this was because of the age and design of Medicaid eligibility systems, which often carry out multiple functions for states—TANF, food stamps, and medical programs—and do not collect detailed medical application outcomes data. Thus, our findings only present information from separate components of combination programs. In Missouri, data on applications include cases for all Medicaid and SCHIP applicants.
- **Unavailability of SCHIP data from 1999.** While we had hoped to measure states' progress by observing data from both May 1999 and May 2000, most states were not able to provide point-in-time data for the earlier period given the newness of programs and systems. Thus, longitudinal comparisons were not possible.
- **Incomparable data across states.** Only five of the eight states were able to provide comparable data on application outcomes. Owing to state variations in the way data are collected and reported, three states had to be analyzed separately (Missouri, North Carolina, New York).
- **Insufficient detail in reporting categories.** Some states could not report data on the specific reasons children are denied eligibility. Others could report data on reasons related to children's failure to meet eligibility criteria, but could not report data on procedural denials of eligibility.

In addition to these gaps in information, the available state data were often reported inconsistently by states, with considerable variation in the definition, classification, collection, and organization of outcome measures. As a result, cross-state comparisons were difficult to make. (Specific cross-state inconsistencies are explained in the "SCHIP Application Outcomes" section, as well as in the detailed notes accompanying tables 2 through 5.)

Despite these challenges, we were able to collect useable data; follow-up interviews with state officials helped us to better understand the nuances of the data states had provided. These interviews were conducted in January/February 2001. Specifically, state officials helped us decide how to group various denial codes into broader

categories for analysis, understand the limitations of states' systems in producing the outcome measures of interest, and interpret the data. Some important issues we learned are summarized below.

- **Number of applications versus number of children.** We learned that while all eight states collected data on the number of application forms that were accepted/denied/referred, only three provided us with data on the actual number of children on these applications that were accepted/denied/referred. Through follow-up conversations, we found that states had different multipliers that could be applied to their application tallies to estimate the number of children that have applied (e.g., Alabama estimates that SCHIP applications account for 1.05 children per application, while Missouri's program has seen 1.96 children per application). Therefore, in our analysis, we report a mix of counts of applications and children.
- **Number of applications/children submitted versus number processed.** We had initially requested data on the number of applications submitted in May 1999 and May 2000. However, we learned that the appropriate denominator for a monthly approval rate should be the number of applications that are processed each month, rather than submitted, because normal processing lags cause large numbers of applications to be pending by each month's end. Many applications that are submitted in the later part of a month are not processed until the next month.
- **Important policy context for interpreting the data.** Developing a clear understanding of each state's policy context was critical for our accurate interpretation of some of the more unusual outcomes. For example, knowing that New York adopted presumptive eligibility helped us understand why the state reported an unusually high rate of initial application approvals.

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36

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